TO AVOID PENALTY, THIS REPORT MUST BE RECEIVED BY INSURER WITHIN 6 WORKING DAYS OF KNOWLEDGE OF THE INJURY

PLEASE PRINT OR TYPE

C3

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

Employer's Name: **CITY OF LAS VEGAS**

Nature of business (mfg., etc.) | SIIC Code

Office Mail Address: **400 STEWART AVENUE**

Location…If different from mailing address | Zip Code

City: **LAS VEGAS, NV 89101**

Telephone

First Name | M.I. | Last Name | Social Security Number | Birthdate | Age

Home Address (Number and Street) | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

City | State | Zip | Was the worker paid for the day of injury? ☐ Yes ☐ No | How long has this person been employed by you in Nevada?

In which state was worker hired? | Employee's occupation (job title) when injured | Department in which regularly employed? | SIIS Class Code (from payroll report)

Telephone | Is the injured worker a corporate officer? ☐ Yes ☐ No …sole proprietor? ☐ Yes ☐ No …partner? ☐ Yes ☐ No | Was worker in your employ when injured? ☐ Yes ☐ No

Date of Injury | Time of Injury (Hour: Minute AM/PM) | Date employer notified of injury | Last day of work after injury | Date of return to work | Number of work days lost | Supervisor to whom injury was reported

Address or location of accident (Also provide city, county, state) | Accident on employer's premises? ☐ Yes ☐ No

What was this employee doing when the accident occurred (Loading truck, walking down stairs, etc.)

Specify machine, tool, substance, or object most closely connected with the accident. | Witnesses

Part of body Injured | If fatal, give date of death. | Witnesses

Nature of Injury (Scratch, cut, bruise, strain, etc.) | Witnesses

Did worker return to next scheduled shift after accident? ☐ Yes ☐ No | Will you have light duty work available, if necessary? ☐ Yes ☐ No

If validity of claim is doubted, state reason.

Treating physician's name | If hospitalized, hospital's name

Address | Address

City | State | Zip | City | State | Zip

Date employee was hired | Was the employee hired to work 40 hours per week? ☐ Yes ☐ No | If not, for how many hours a week was the employee hired?

Does the employee receive commissions? ☐ Yes ☐ No
If the employee receives commissions, indicate the amount received over the last 6 months or since the date of hire. $

Indicate the period of time for which the commissions were paid. From: To:
Is this amount included in the gross earnings below? ☐ Yes ☐ No

Does the employee declare tips for the purpose of receiving workers' compensation? ☐ Yes ☐ No ***If yes,*** *provide tip information in the space provided below and attach copies of the declartion forms.*

Did the employee receive unemployment compension any time during the last 12 months? ☐ Yes ☐ No ☐ Do Not Know

Did the employee receive any bonus pay during the last 12 months? ☐ Yes ☐ No | If the employee did receive bonus pay, indicate the amount paid during the last 12 months? $

Does the employee receive meals or lodging *(excluding per diem)* ☐ Yes ☐ No | If the employee does receive meals or lodging, indicate what monetary value is placed on…

Meals? $ per
Lodging? $ per

In the space provided below, please indicate the employee's **gross earnings** for 12 weeks prior to the date of injury, **gross earnings** will include overtime and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury. In addition, if the employee was absent from work during the period for which payroll information is requested for any of the reasons listed below, please provide the date(s) absent and, from the following list, indicate, *by numeral,* the reason(s) for the absence(s).

1. Certified illness of disability.
2. Institutionalized in prison, hospital, or other institution.
3. Enrolled as a full-time student, not employed on days when attending classes.
4. In military service other than that training duty conducted on weekends.
5. Absent because of an officially sanctioned strike.

Beginning Payroll Period Ending	Gross Earnings	Declared Tips	Beginning Payroll Period Ending	Gross Earnings	Declared Tips

Absence began on: / Absence ended on: / Reason	Absence began on: / Absence ended on: / Reason	Absence began on: / Absence ended on: / Reason	Absence began on: / Absence ended on: / Reason	Absence began on: / Absence ended on: / Reason

Pay period ends on: ☐ SUN ☐ TUE ☐ THU ☐ SAT ☐ MON ☐ WED ☐ FRI

Employee is paid: ☐ WKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY

On the date of injury, the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

I affirm that the information provided above regarding the accident and injury is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's signature and title | Date

INSURER USE ONLY

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party | Deemed Wage | Account Number | Class Code

Status Clerk | Date | Claims examiner's signature | Date

Brief Description of Your Rights and Benefits If You Are Injured on the Job *(NRS 616 and 617)*

Notice of Injury or occupational Disease (Incident Report Form C-1): If an injury occurs out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but within **7 days** after the accident.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. You must complete a "Claim for Compensation" form (Form C-4) within **90 days** after an accident. The treating physician or chiropractor must within **3 working days** after treatment, complete and mail to the employer and to the employer's insurer, the Claim for Compensation. The employer must complete and mail to his insurer or third-party administrator an Employer's Report of Industrial Injury or Occupational Disease (Form C-3), within **6 working days** after receipt of a Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury, you may be required to select a physician or chiropractor from a list provided by your employer. If you have any questions concerning the law as it may apply to you, contact your insurer.

Acceptance or Denial: An insurer must accept or deny responsibility for compensation within **30 working days** after a Claim for Compensation (Form C-4) is received.

Lost Time Compensation: If your doctor has certified that you are unable to work for a period of 5 consecutive days or more, or 5 cumulative days in a 20-day period, you may be entitled to temporary total disability compensation. Payments for lost time are paid at 66 2/3 percent of your average monthly wage and limited by the state average weekly wage that is established and certified by the Nevada State Employment Security Department.

Travel Reimbursement: You may be entitled to reimbursement for travel expenses directly related to treatment for your injury. If you are required to travel 20 miles or more one way, or 40 miles or more in one week, for medical treatment, you may be reimbursed for the cost of transportation. A claim for such reimbursement must be submitted to the insurer within 60 days after the travel took place. The travel reimbursement claim form (D-26) is available from the insurer, employer or third-party administrator if the employer is self insured, or from SIIS, if the employer is insured by SIIS.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to your job due to a permanent physical impairment as a result of your injury.

Permanent Partial Disability: When your medical condition is stable and there is an indication of permanent impairment as a result of your injury, your insurer must schedule an evaluation within 30 days by a rating physician or chiropractor to determine the degree of permanent partial disability.

Claim Closure: If the medical benefits paid for a claim are less than $500, the claim closes automatically if you do not receive medical treatment for the injury for at least 12 months. If the medical benefits paid on a claim exceed $500 and the insurer determines the claim should be closed, the insurer shall send a written notice of its intention to close the claim.

Reopening: Nevada Revised Statutes 616C.390 defines your right to reopen your workers' compensation claim, after it has been determined that all benefits were paid and your claim has been closed. An application to reopen a claim must be in writing and accompanied by a certificate from a physician or chiropractor showing a change in medical condition. If you did not lose time from work as a result of your industrial injury and you did not sustain a permanent partial disability, reopening of your claim must be requested within one (1) year after the date on which your claim was closed. If the request for reopening is denied, you shall not reapply to reopen your claim until at least one (1) year after the date on which the final determination of the insurer was made. Reopening of a claim is not effective before an application for reopening is made.

Appeal Rights: If you disagree with a written determination made by your insurer, you may appeal by following the instructions contained in your determination letter within 70 days after the date on which the final notice was mailed by your insurer.

The descriptive material contained in this publication is derived from Chapters 616 and 617 of the Nevada Revised Statutes and is provided for informational purposes only.

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